

HOUSE RESEARCH ORGANIZATION • TEXAS HOUSE OF REPRESENTATIVES

P.O. Box 2910, Austin, Texas 78768-2910
(512) 463-0752 • <https://hro.house.texas.gov>

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HOUSE RESEARCH ORGANIZATION

daily floor report

Wednesday, April 14, 2021
87th Legislature, Number 34
The House convenes at 10 a.m.
Part One

Two bills are on the Major State Calendar, one joint resolution is on the Constitutional Amendments Calendar, and 31 bills are on the General State Calendar for second reading consideration today. The bills analyzed or digested in Part One of today's *Daily Floor Report* are listed on the following page.

The following House committees were scheduled to meet today: State Affairs; Public Health; Corrections; International Relations and Economic Development; Pensions, Investments and Financial Services; Judiciary and Civil Jurisprudence; Licensing and Administrative Procedures; Urban Affairs; Business and Industry; and Elections.



Alma Allen
Chairman
87(R) - 34

HOUSE RESEARCH ORGANIZATION

Daily Floor Report

Wednesday, April 14, 2021

87th Legislature, Number 34

Part 1

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SUBJECT: Allowing certain telehealth and telemedicine services under Medicaid

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Klick, Guerra, Allison, Jetton, Oliverson, Price, Zwiener

0 nays

4 absent — Campos, Coleman, Collier, Smith

WITNESSES: For — Dennis Borel, Coalition of Texans with Disabilities; Laurie Vanhooose, Texas Association of Health Plans; Robert Ball, Texas Children's Hospital; Lee Johnson, Texas Council of Community Centers; Nora Belcher, Texas e-Health Alliance; Cameron Duncan, Texas Hospital Association; Hani Talebi, Texas Psychological Association; (*Registered, but did not testify*: Blake Hutson, AARP Texas; Priscilla Camacho, Alamo Colleges District; Aaron Gregg, Alzheimer's Association; Justin Keener, Americans for Prosperity and Libre Initiative; Gregg Knaupe, Ascension Texas and Texas Association for Home Care and Hospice; Amy Bresnen, Association of Dental Support Organizations; Lisa Poynor, Association of Substance Abuse Programs of Texas; Marisa Finley, Baylor Scott and White Health; Melissa Shannon, Bexar County Commissioners Court; Kwame Walker, Catholic Health Initiatives; Kyle Mauro, Central Health; Allison Greer Francis and David Pan, CHCS; Michaela Bennett, Children's Health; Amber Hausenfluck, CHRISTUS Health; Christine Wright, City of San Antonio; Christine Bryan, Clarity Child Guidance Center; Steve Koebele, Concentra; Adam Haynes, Conference of Urban Counties; Jim Allison, County Judges and Commissioners Association of Texas; Roberto Haddad, Doctors Hospital at Renaissance (DHR Health); Michael Dole, Driscoll Health Plan; Lindsay Munoz, Greater Houston Partnership; Thamara Narvaez, Harris County Commissioners Court; Fred Shannon, Intel Corporation; Rick Bailey, Johnson County; Lindsay Lanagan, Legacy Community Health; Bill Kelly, Mayor's Office for City of Houston; Myra Leo, Methodist Healthcare Ministries; Christine Yanas, Methodist Healthcare Ministries of South Texas, Inc.; Greg Hansch, National Alliance on Mental Illness-Texas; Alison Mohr Boleware, National Association of Social Workers-Texas Chapter; Chris Wallace,

North Texas Commission; Martin Gutierrez, San Antonio Hispanic Chamber of Commerce; Russell Schaffner, Tarrant County; Grover Campbell, TASB; Jessica Schleifer, Teaching Hospitals of Texas; Adriana Kohler, Texans Care for Children; Charles Miller, Texas 2036; Marshall Kenderdine, Texas Academy of Family Physicians and Texas Society for Gastroenterology and Endoscopy; Santiago Cirnigliaro, Texas Alliance of Child and Family Services; Courtney Hoffman, Texas Association for Behavior Analysis Public Policy Group; Megan Herring, Texas Association of Business; Kay Ghahremani, Texas Association of Community Based Plans; Shelby Tracy, Texas Association of Community Health Centers; David Reynolds, Texas Chapter American College of Physicians; Mia McCord, Texas Conservative Coalition (TCC); Matt Roberts, Texas Dental Association; Gavin Gadberry, Texas Health Care Association; Reed Clay, Texas Health Resources; Dan Finch, Texas Medical Association; Casey Haney, Texas Nurse Practitioners; Kevin Stewart, Texas Nurses Association; Denise Rose, Texas Occupational Therapy Association; Trent Krienke, Texas Organization of Rural and Community Hospitals; Jill Sutton, Texas Osteopathic Medical Association; Clayton Travis, Texas Pediatric Society; Jessica Karlsruher, Texas Real Estate Advocacy and Defense Coalition; Lawrence Higdon, Texas Speech Language Hearing Association; Dana Harris, The Greater Austin Chamber of Commerce; Leah Rummel, United HealthCare; Molly Weiner, United Ways of Texas; Andrew Smith, University Health; Elisa Hernandez, University Medical Center of El Paso; Knox Kimberly, Upbring)

Against — None

On — (*Registered, but did not testify*: Monica Ayres, Citizens Commission on Human Rights Texas)

BACKGROUND: Occupations Code sec. 111.001 defines "telehealth service" and "telemedicine medical service" as health care provided through telecommunication technology by a practitioner in a different location from the patient receiving the care. In telemedicine the practitioner in charge of delivering the care is a physician, while in telehealth it is another health professional who is not under a physician's supervision or delegation authority.

Government Code sec. 531.02164 limits home telemonitoring services under Medicaid only to persons who are diagnosed with at least one specified health condition, including pregnancy, diabetes, heart disease, cancer, and mental illness, and who exhibit at least two specified risk factors.

Sec. 533.0061 establishes minimum standards to ensure a managed care organization provides Medicaid recipients sufficient access to certain services, such as primary and specialty care and nursing and therapy services, among others.

Sec. 531.0216(i) authorizes a federally qualified health center to be reimbursed for the originating site facility fee and/or the distant site practitioner fee for a covered telemedicine or telehealth service provided to a Medicaid recipient. This requirement applies only if the Legislature appropriates money for this purpose. Otherwise, the executive commissioner of the Health and Human Services Commission may implement this provision using other available funds appropriated for that purpose.

Health and Safety Code sec. 62.1571 requires a Children's Health Insurance Program health plan provider to allow a child's covered benefits to be provided through telemedicine medical services.

DIGEST:

CSHB 4 would require the executive commissioner of the Health and Human Services Commission (HHSC) to establish policies, procedures, and otherwise ensure certain health care services could be provided through telehealth, telemedicine, telecommunications, or other information technology.

Telehealth and telemedicine services. By January 1, 2022, HHSC would have to ensure that enrollees in Medicaid, the Children's Health Insurance Program (CHIP), and other specified public benefits programs had the option to receive certain services as telemedicine or telehealth services, or otherwise use telecommunications or information technology, regardless of whether the services were provided through managed care or another delivery model. This provision would apply to the following services:

- preventative health and wellness;
- case management, including targeted case management;
- certain behavioral health services;
- occupational, physical, and speech therapy;
- nutritional counseling; and
- assessments, including nursing assessments under certain Section 1915(c) home and community-based services waiver programs.

HHSC would have to ensure the required service options were provided only if permitted by federal law and if the commission determined it was cost-effective and clinically effective.

Audio-only services. Under the bill, HHSC by rule would have to develop and implement a system to ensure behavioral health services could be provided using audio-only technology to enrollees in Medicaid, CHIP, and other specified public benefits programs. The executive commissioner of HHSC by rule could provide audio-only technology through non-behavioral health services if the executive commissioner determined that using that technology would be cost-effective and clinically effective.

HHSC would have to implement these audio-only provisions by January 1, 2022.

Medicaid managed care. The bill would require HHSC to establish policies and procedures for improving access to care under the Medicaid managed care program by encouraging the use of telehealth services, telemedicine medical services, home telemonitoring services, and other telecommunications or information technology.

Reimbursement for home telemonitoring services. The bill would allow a Medicaid managed care organization (MCO) to reimburse providers for home telemonitoring services provided to persons and in circumstances other than those specified in Government Code sec. 531.02164. The MCO would have to consider whether the reimbursement for the service would be cost-effective and providing the service would be clinically effective.

Text messaging. By January 1, 2022, the executive commissioner would have to adopt and publish guidelines for MCOs on how they could communicate by text message with enrollees, which would include standardized consent language.

Home and community-based services. To the extent permitted by federal law, HHSC would have to establish policies and procedures that allowed a Medicaid MCO to conduct assessments of and provide care coordination services to recipients receiving home and community-based services using other telecommunication or technology if those methods were deemed appropriate by the MCO or HHSC. The bill also would permit telecommunication and information technology for the assessments and care coordination services if requested by the recipient, or if an in-person assessment or activity would not be feasible because of an emergency or state of disaster, including a public health emergency or natural disaster.

HHSC would be required to determine categories of recipients of home and community-based services who must receive in-person visits. Except when not feasible due to a public health emergency or disaster, the bill would require an MCO to conduct for a recipient of home and community-based services at least one in-person visit with the recipient, and additional visits if necessary, as determined by the MCO.

If an MCO assessed or provided care coordination services to a recipient using telecommunications or information technology, the MCO would have to monitor the provided health care services for evidence of fraud, waste, and abuse and determine whether additional social services or supports were needed. HHSC would have to allow a recipient receiving certain services using telecommunication and information technology to consent verbally instead of in writing.

Provider access standards. The bill would require provider access standards for Medicaid managed care to include consideration of and the availability of telehealth and telemedicine services within an MCO's provider network.

Reimbursement for rural health clinics. The bill would establish that a rural health clinic as defined by 42 U.S.C. sec. 1396d(l)(1) was eligible

for reimbursement for certain fees under Government Code sec. 531.0216(i).

Other provisions. The bill would make conforming changes under Health and Safety Code sec. 62.1571 by requiring telehealth services also be offered as covered benefits to CHIP enrollees.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2021.

**SUPPORTERS
SAY:**

CSHB 4 would improve access to health care for Texans, especially those in rural and medically underserved areas, by allowing multiple services to be provided through telemedicine, telehealth, telecommunications, or other information technology.

During the COVID-19 pandemic, demand for telehealth and telemedicine services increased due to heightened mental health needs exacerbated by illness, fear, and social and economic hardship. In response, many health care providers quickly shifted from providing in-person visits to using telehealth and telemedicine and other remote technology tools. This bill would preserve telehealth and telemedicine efforts made in the pandemic to address provider shortages and provide Texans access to virtual health care services beyond the public health emergency. The bill also would establish sufficient protections for Texans by requiring the Health and Human Services Commission to determine whether providing virtual services would be cost-effective and clinically effective.

By increasing access to telemedicine and telehealth, the bill would ensure continuity of care and could generate cost-savings for families and the state. Providing telemedicine, telehealth, and telecommunication services could help families save time and money that they might otherwise spend traveling to appointments or finding child care. Elderly and medically fragile individuals, who often have limited mobility, also would benefit from virtual appointments. Allowing services like preventative health and wellness and care coordination to be provided through telemedicine and telehealth could help practitioners improve "no-show" appointment rates,

identify patients' health issues early, efficiently refer a patient to a specialist, and help decrease emergency room visits.

Allowing audio-only benefits for behavioral health services would address a gap in health care services and create flexibility for patients and providers. Many Texans do not have internet access or smartphones, making audio-only their most viable option. Additionally, an audio-only option could help reduce stigma for patients seeking mental health and substance use disorder services.

CRITICS
SAY:

CSHB 4 could reduce the quality of health care by allowing audio-only benefits to be provided for certain behavioral health services. A health practitioner may not be able to accurately assess a patient through audio-only technology.

OTHER
CRITICS
SAY:

While CSHB 4 makes significant strides to advance telehealth and telemedicine services for Texans beyond the pandemic, the bill should require health care professionals' reimbursement rates for telemedicine and telehealth services to be the same rate as those for in-person services. Providing payment parity would help encourage more providers to use telehealth and telemedicine services.

SUBJECT: Creating a prescription drug savings program for uninsured individuals

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Oliverson, Vo, J. González, Hull, Israel, Middleton, Paul,
Romero, Sanford

0 nays

WITNESSES: For — Blake Hutson, AARP Texas; Veronica De La Garza, American Diabetes Association; Melodie Shrader, Pharmaceutical Care Management Association; Jamie Dudensing, Texas Association of Health Plans; David Balat, Texas Public Policy Foundation; Jason Ryan; (*Registered, but did not testify*: Michael Wright, American Pharmacies; Kandice Sanaie, Cigna; Dennis Borel, Coalition of Texans with Disabilities; Mark Vane, GoodRx; Myra Leo, Methodist Healthcare Ministries; Charles Miller, Texas 2036; Bill Hammond, Texas Employers for Insurance Reform; Cameron Duncan, Texas Hospital Association; Clayton Stewart, Texas Medical Association; Jill Sutton, Texas Osteopathic Medical Association; KeShana Odom, Texas Society of Health-System Pharmacists; Jennifer Allmon, The Texas Catholic Conference of Bishops; Andrew Smith, University Health)

Against — None

On — Debbie Garza, Texas Pharmacy Association; (*Registered, but did not testify*: Jenny Blakey, OPIC)

DIGEST: CSHB 18 would require the Health and Human Services Commission (HHSC) to develop and design a prescription drug savings program that partnered with a pharmacy benefit manager (PBM) to offer prescription drugs at a discounted rate to uninsured individuals. The program would use money from a new trust fund to pay an amount equal to the value of a prescription drug rebate at the point of sale and returning that rebate amount to the fund to ensure credited and paid amounts equaled each other.

The bill also would establish eligibility criteria and cost-sharing requirements for uninsured individuals in the program, specify the roles of HHSC and PBMs, and create a trust fund outside of the state treasury. "Uninsured individual" would mean an individual without health benefit plan coverage for a prescription drug benefit.

Eligibility and cost-sharing. An individual would be eligible for the drug savings program if the individual was: a resident of Texas; a citizen or lawful permanent resident of the United States; and uninsured, as determined by HHSC.

An applicant's financial vulnerability could be considered as an additional factor for program eligibility as determined by HHSC.

The bill would require HHSC to conduct or enter into a contract to do a community outreach and education campaign to provide information on the program's availability to eligible individuals.

Cost-sharing. To the extent necessary, the bill would require enrollees to share the cost of the program, including paying a copayment at the prescription drug's point of sale. HHSC would have to allow an enrollee to pay all or part of the enrollee's share from any source the enrollee selected and accept another assistance program if it wholly or partly covered the enrollee's share of the drug cost.

Under the bill, enrollees would have to pay the costs of the program's ongoing administration through an additional charge at an eligible prescription drug's point of sale only if the total number of enrollees allowed for the additional charge to not exceed the lesser of \$4 or 10 percent of the total amount charged at the drug's point of sale. HHSC would require an enrollee to pay a copayment to compensate the pharmacy, PBM, and commission for the costs of administering the program.

Program design and benefits. The executive commissioner of HHSC would have to ensure the drug savings program was designed to provide the greatest possible value to eligible uninsured individuals, while considering the adequacy of the prescription drug formulary, net costs of

the drugs to enrollees, cost to the state, and other factors determined by HHSC. The commission would have to:

- design the program to be cost neutral by collecting drug rebates after using money in the fund equal to rebate amounts to purchase prescription drugs;
- ensure the program had access to an adequate pharmacy network and give preference to conducting the program using a state pharmaceutical assistance program;
- ensure the program benefits did not include prescription drugs used for elective termination of a pregnancy; and
- develop procedures for accepting applications, including screening, enrollment, and determining and resolving disputes about eligibility.

The commission would have to ensure the program benefits complied with all applicable federal and state laws, rules, and regulations. HHSC also would have to publish on a website all average consumer costs for each prescription drug available through the discounted drug program.

Program suspension. On the fourth anniversary after the drug savings program was established, the bill would require HHSC to suspend the program and seek legislative approval to continue the program if available federal money for the one-time start-up costs was depleted and the ongoing costs of administering the program were not fully funded through enrollee cost sharing.

Contracts. The commission would not be required to enter into stand-alone contracts under the bill and could add the program, wholly or partly, to existing contracts to increase efficiency. The bill would allow HHSC to contract with a third-party administrator or other entity to perform any or all program functions and could delegate policy decisions to the administrator or other entity.

Pharmacy benefit managers. Under the bill, HHSC would have to contract with a pharmacy benefit manager (PBM) to provide discounted prescription drugs to program enrollees. The commission would monitor

through reporting the PBM to ensure performance and quality delivery of services.

The contracted PBM would have to report certain information upon the commission's request, including rebate amounts, prescription drug rates contracted with pharmacies, administrative costs, and out-of-pocket costs paid by enrollees at the drug's point of sale.

Trust fund. The bill would establish a trust fund outside the state treasury only if the state received federal money that could be used for Health and Safety Code ch. 65 and that federal money was directed to be deposited to the credit of the fund as provided by law. The fund would include:

- gifts, grants, and donations received by the state for the fund's purpose;
- legislative appropriations of money;
- federal money available to this state by law; and
- interest, dividends, and other income of the fund.

The bill would prohibit HHSC from implementing the drug savings program unless federal money was provided to the state and by law made available for deposit to the trust fund. HHSC would have to ensure money spent from the trust fund to assist enrollees in purchasing prescription drugs was cost neutral after collecting the prescription drug rebates.

Under the bill, HHSC would administer the fund as trustee for the benefit of the drug savings program. Money in the fund could be used only to administer the program and provide program services. HHSC could solicit and accept gifts, grants, and donations for the fund.

The following provision would expire September 1, 2025: the bill would allow HHSC to pay the program's one-time start-up costs only with federal money in the trust fund.

Studies and reports. The bill would require HHSC to conduct two studies on the drug savings program's development and implementation regarding providing to enrollees post-rebate insulin and post-rebate formulary of prescription drugs. In conducting the studies, the

commission would determine the program's effectiveness in providing insulin-related services to this state's uninsured individuals and any legislative recommendations.

By February 14, 2023, HHSC would have to provide a written report of the post-rebate insulin study to the governor, lieutenant governor, the House speaker, and relevant legislative committees. That study would have to include at least six months of information on use by and cost to enrollees for prescription insulin.

By February 14, 2025, HHSC would have to provide a written report on the study for post-rebate formulary of prescription drugs to the governor, lieutenant governor, the House speaker, and relevant legislative committees. That study would have to include at least one year of information on use by and cost to enrollees for all of the formulary of prescription drugs.

Other reports. A third-party administrator, PBM, or any other contracted entity would have to submit to HHSC a report that included the provided program benefits and services.

By December 1 of each year, HHSC would have to provide a written report to the governor, lieutenant governor, the House speaker, and relevant legislative committees, including:

- a line-item list of all program administrative costs incurred by HHSC;
- the amount of PBM and third-party administrator fees;
- the aggregate amounts of anticipated and received rebates; and
- other program expenditures.

This initial report would not be due until December 1, 2022.

Other provisions. The bill would not establish an entitlement to assistance in obtaining benefits for uninsured individuals nor would it expand the Medicaid program.

As soon as practicable after the bill's effective date, the executive commissioner of HHSC would have to adopt rules to implement provisions under Health and Safety Code ch. 65, including fraud prevention and detection for PBMs, contracted third parties, and other entities involved in the program.

The bill would take effect September 1, 2021.

**SUPPORTERS
SAY:**

CSHB 18 would increase access to affordable prescription drugs for uninsured Texans by creating a drug savings program. As pharmaceutical drug prices continue to rise, high out-of-pocket costs for prescription drugs can lead to patients foregoing needed medication, like insulin, which can increase hospitalization rates. By creating a prescription drug savings program, the bill would ensure uninsured Texans had access to life-saving medications and could improve their medication adherence, leading to better health outcomes.

Additionally, establishing a trust fund outside of the state treasury would avoid using state funds to pay for the drug savings program and would not pass program costs on to employers. The bill would enable the state to leverage better rates for prescription drugs like insulin and pass along those savings to uninsured Texans.

The bill would provide rulemaking flexibility to the Health and Human Services Commission to adopt an appropriate payment structure while ensuring an adequate pharmacy network.

**CRITICS
SAY:**

CSHB 18 should include stronger protections for pharmacies by requiring reimbursements from the pharmacy benefit manager (PBM) to reflect pharmacies' actual acquisition costs of prescription drugs and the cost to dispense those medications. PBMs regularly reimburse pharmacies below a pharmacy's cost to acquire and dispense prescription medications. Without clearer guidance on pharmacy reimbursements, the bill could create a payment structure that would not ensure rebate dollars were fully applied at the point of sale, potentially increasing a pharmacy's operational costs.

SUBJECT: Authorizing local option homestead exemption for certain physicians

COMMITTEE: Ways and Means — favorable, without amendment

VOTE: 10 ayes — Meyer, Thierry, Button, Cole, Guerra, Martinez Fischer,
Murphy, Noble, Rodriguez, Shine

0 nays

1 absent — Sanford

WITNESSES: None

DIGEST: HJR 25 would amend the Texas Constitution to allow a county commissioners court to exempt from county property taxation up to 50 percent of the assessed value of the residence homestead of certain physicians. The exemption would be for a licensed physician who provided health care services for which they did not seek payment from any source, including Medicaid or other state or federal programs, to county residents who were indigent or Medicaid recipients.

This exemption would be in addition to any other residence homestead exemption provided by the Texas Constitution. The Legislature by general law could impose additional eligibility requirements for the exemption.

Where property tax had previously been pledged for debt payment, the commissioners court could continue to levy and collect the tax against the value of the exempted homesteads until the debt was discharged if the cessation of the levy would impair the obligation of the contract that created the debt.

The ballot proposal would be presented to voters at an election on November 2, 2021, and would read: "The constitutional amendment authorizing a local option exemption from ad valorem taxation by a county of a portion of the value of the residence homestead of a physician who provides health care services for which the physician agrees not to seek payment from any source, including the Medicaid program or

otherwise from this state or the federal government, to county residents who are indigent or who are Medicaid recipients."

SUPPORTERS
SAY:

HJR 25 and its enabling legislation, HB 457, would improve access to health care and reduce costs to the state by creating a tool for counties to incentivize physicians to participate in indigent health care. Existing care programs are growing more costly and the number of physicians in indigent programs is declining as they become frustrated over the administration of Medicaid. These barriers have caused health care programs for low-income or indigent patients to struggle to meet demand.

The legislation would address this issue by allowing a county to adopt a residence homestead exemption for physicians who provided health care to indigent residents or Medicaid recipients free of charge. This exemption could ease the burden on government programs, reduce uncompensated care costs, and engage the private sector on a volunteer basis.

The residence homestead exemption would be optional, allowing counties to limit property taxation by up to 50 percent for eligible physicians if they determined it useful. The enabling legislation also would provide that counties could determine eligibility for the exemption, allowing localities to tailor the exemption to their own revenue and health care needs.

CRITICS
SAY:

HJR 25 and HB 457 unnecessarily would create a residence homestead exemption on property taxes for physicians providing health care to indigent residents and Medicaid recipients. Instead of carving out specific individuals from the tax base, limiting local revenues, the Legislature should expand Medicaid to provide effective health care to Texans.

OTHER
CRITICS
SAY:

HJR 25 and HB 457 would provide another property tax exemption for a specialized group, while the Legislature should be working to lower the tax burden on all Texans. The legislation would continue a problematic trend that increases the burden on some homeowners by lowering it for others.

NOTES:

HB 457 by Shaheen, the enabling legislation for HJR 25, is set for second-reading consideration today.

According to the fiscal note, the proposed constitutional amendment, if approved by the voters, would create a cost to counties that chose to grant the partial residence homestead exemption. However, the number of counties that would grant the exemption, the number of physicians who would qualify, and the amount of property value that would be exempted are unknown so the cost cannot be estimated.

The cost to the state for publication of the resolution is \$178,333.

SUBJECT: Enacting the Interstate Medical Licensure Compact in Texas

COMMITTEE: Public Health — favorable, without amendment

VOTE: 11 ayes — Klick, Guerra, Allison, Campos, Coleman, Collier, Jetton, Oliverson, Price, Smith, Zwiener

0 nays

WITNESSES: For — Rick Masters and Marschall Smith, Interstate Medical Licensure Compact Commission; Robert Ball, Texas Children’s Hospital; Nora Belcher, Texas e-Health Alliance; Dan Finch, Texas Medical Association; Jennifer Allmon, The Texas Catholic Conference of Bishops; (*Registered, but did not testify*: Gregg Knaupe, Ascension Texas; Amber Hausenfluck, CHRISTUS Health; Lindsay Munoz, Greater Houston Partnership; Jessica Schleifer, Teaching Hospitals of Texas; Charles Miller, Texas 2036; Marshall Kenderdine, Texas Academy of Family Physicians; Laurie Vanhoose, Texas Association of Health Plans; Mia McCord, Texas Conservative Coalition; Cameron Duncan, Texas Hospital Association; Trent Krienke, Texas Organization of Rural and Community Hospitals; Bobby Hillert, Texas Orthopaedic Association; Bonnie Bruce, Texas Society of Anesthesiologists)

Against — (*Registered, but did not testify*: Jill Sutton, Texas Osteopathic Medical Association)

On — Welela Tereffe, UT MD Anderson Cancer Center; (*Registered, but did not testify*: Stephen Carlton, Texas Medical Board; John Seago, Texas Right to Life)

BACKGROUND: The Interstate Medical Licensure Compact is an agreement made among participating states to streamline the process of licensing for physicians seeking to practice in multiple states. The compact, which currently consists of 29 states, creates an expedited pathway for certain eligible physicians to voluntarily pursue a medical license. The goal of the compact is to increase access to health care in underserved or rural areas.

The Interstate Medical Licensure Compact Commission administers the compact's rules, policies, and procedures. The commission is composed of two representatives from each participating state and conducts regularly scheduled meetings open to the general public.

DIGEST:

HB 1616 would enact the Interstate Medical Licensure Compact in Texas. The bill contains provisions related to expedited licensure for eligible physicians, investigations, disciplinary actions, oversight and enforcement of the compact, and withdrawal from the compact.

Interstate Medical Licensure Compact Commission. The bill would codify the rights, duties, responsibilities, powers, finances, and other obligations of the Interstate Medical Licensure Compact Commission.

Expedited licensure. Under the bill, an expedited license would be a full and unrestricted medical license granted by a compact member state to an eligible physician. An expedited license would authorize a physician to practice medicine in the issuing state consistent with the medical practice act and all applicable laws and regulations of the state.

Eligibility. To receive an expedited license under the terms and provisions of the compact, a physician would have to:

- be a graduate of a medical school accredited by certain agencies;
- have passed each component of the United States Medical Licensing Examination or the Comprehensive Medical Licensing Examination within three attempts, or any of its predecessor examinations accepted by a state medical board;
- have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
- hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;
- possess a full and unrestricted license to engage in the practice of medicine issued by a member board;

- never have been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- never have held a license authorizing the practice of medicine subjected to discipline by a licensing agency, excluding any action related to nonpayment of license fees;
- never have had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration; and
- not be under active investigation by a licensing agency or law enforcement authority.

A physician who did not meet these requirements could obtain a license to practice medicine in a member state if the individual complied with all laws and requirements relating to the issuance of a license to practice medicine in that state.

Application. A physician seeking licensure through the compact would have to file an application with the member board of the state selected by the physician as the state of principal license. The member board within the state selected would have to evaluate the applicant's eligibility for expedited licensure and issue a letter of qualification to the interstate commission.

Background check. The member board would have to perform a criminal background check on an applicant for expedited licensure that included the results of fingerprint or other biometric data checks compliant with requirements of the Federal Bureau of Investigation, excluding certain federal employees.

Registration. Upon verification, eligible physicians would have to complete the registration process established by the interstate commission to receive a license in the selected member state, including the payment of any applicable fees. Upon receiving verification of eligibility and fees, a member board would have to issue an expedited license to the physician.

Validity. An expedited license would be valid for a period consistent with the licensure period in the member state and in the same manner as

required for other physicians holding a full and unrestricted license within the member state.

Termination. An expedited license obtained through the compact would be terminated if a physician failed to maintain a license in the state of principal licensure for a nondisciplinary reason, without redesignation of a new state of principal licensure.

Renewal. A physician seeking to renew an expedited license would have to complete a renewal process with the interstate commission if the physician:

- maintained a full and unrestricted license in a state of principal license;
- had not been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- had not had a license authorizing the practice of medicine subject to discipline by a licensing agency, excluding any action related to nonpayment of license fees; and
- had not had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration.

Physicians holding expedited licenses would have to comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

Fees. A member state that issued an expedited license authorizing the practice of medicine in that state could impose a fee for a license issued or renewed through the compact. The interstate commission would collect any renewal fees and distribute them to the applicable member board. A member board would have to renew the physician's license upon the receipt of renewal fees.

State of principal license. A physician would have to designate a member state as the state of principal license for the purposes of registration for expedited licensure through the compact if the physician possessed a full

and unrestricted license to practice medicine in that state, and the state was:

- the state of primary residence for the physician;
- the state where at least 25 percent of the physician's practice of medicine occurred;
- the location of the physician's employer; or
- if no state qualified under the preceding criteria, the state designated as state of residence for federal income tax purposes.

A physician could redesignate a member state as a state of principal license at any time, as long as the state met these requirements.

Joint investigations. A member board could participate with other member boards in joint investigations of physicians licensed by the member boards. A subpoena issued by a member state would be enforceable in other member states.

Member boards could share any investigative, litigation, or compliance materials in furtherance of an investigation initiated under the compact. Any member state could investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician held a license to practice medicine.

Disciplinary actions. Any disciplinary action taken by a member board against a physician licensed through the compact would be considered unprofessional conduct which could be subject to discipline by other member boards, in addition to any violation of the medical practice act or regulations in that state.

If a license granted to a physician by the member board in the state of principal license was revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards would automatically be placed on the same status.

If a license granted to a physician by a member board was revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board would be

suspended automatically and immediately for 90 days. A member board could terminate the automatic suspension of the license it issued before the completion of the 90-day suspension period.

If disciplinary action was taken against a physician by a member board not in the state of principal license, any other member board could consider the action conclusive as to matter of law and fact decided and impose the same or lesser sanction against the physician or pursue separate disciplinary action against the physician.

A member board would have to report to the interstate commission any public action or complaint against a licensed physician who applied for or received an expedited license through the compact. A board also could report any nonpublic complaint, disciplinary, or investigatory information to the interstate commission.

Member boards would have to share complaint or disciplinary information about a physician upon request of another member board, and all information provided to the interstate commission or distributed by member boards would be confidential.

Oversight and enforcement. The executive, legislative, and judicial branches of state government of each member state would enforce the compact and would have to take all actions necessary and appropriate to enforce the provisions of the compact. The compact's provisions would not override existing state authority to regulate the practice of medicine.

All laws in a member state in conflict with the compact would be superseded to the extent of the conflict. All lawful actions of the interstate commission and all agreements between the commission and member states would be binding upon member states. If a provision of the compact exceeded the constitutional limits imposed on the legislature of any member state, such provision would be ineffective to the extent of conflict with the constitutional provision.

Nothing in the compact could be construed to prohibit the applicability of other interstate compacts to which the states are members.

Withdrawal from the compact. A member state could withdraw from the compact by specifically repealing the enacting statute. Withdrawal from the compact would not take effect until one year after the effective date of the repealing statute and until written notice of the withdrawal had been given to the governor of each other member state.

The withdrawing state immediately would have to notify the chairperson of the interstate commission in writing upon the introduction of legislation repealing the compact in the withdrawing state. The withdrawing state would be responsible for all dues, obligations, and liabilities incurred through the effective date of withdrawal.

Effective date. The compact would become effective and binding on a state upon enactment of the compact into law.

The bill would take effect September 1, 2021.

**SUPPORTERS
SAY:**

HB 1616 would increase access to health care for rural and underserved areas in the state while allowing the Texas Medical Board to retain oversight of the medical profession by entering Texas into the Interstate Medical Licensure Compact. The bill would maintain the state's sovereign oversight of the medical profession in Texas, result in a net fiscal benefit to the state, and allow physicians to choose whether or not to participate in the compact.

The temporary relaxation of certain physician licensing requirements during the COVID-19 pandemic allowed states greater flexibility in providing and receiving health care, including through telemedicine. By joining the Interstate Medical Licensure Compact, Texas would be able to take advantage of this flexibility and provide increased access to health care to rural and underserved populations throughout the state. Allowing physicians from other states that were members of the compact to receive expedited licenses to practice in Texas would bolster the state's supply of medical providers and provide more choice in health care to Texans.

The bill would not burden physicians with the requirement to hold a specialty certification since this requirement would apply only at the time of application and would not be ongoing. The bill would not remove the

Texas Medical Board's oversight of the medical profession and licensing in Texas, nor allow unqualified physicians to practice in the state. Joining the compact would not sacrifice the state's sovereignty, as Texas would be free to leave at any time. Furthermore, physicians would not be forced to participate in the program.

The bill would not create financial obligations for the state, as licensing fees paid by participants would cover the costs of the compact. Additionally, the Legislative Budget Board projected that HB 1616 would bring in around \$480,000 to the state over the 2022-23 biennium.

CRITICS
SAY:

HB 1616 could decrease access to care for rural Texans by requiring physicians participating in the compact to possess a specialty certification from the inefficient American Board of Medical Specialties. The bill also could sacrifice Texas sovereignty and physician autonomy by tying the state to an inefficient and unaccountable out-of-state board and create unnecessary financial obligations for the state. Instead of joining the Interstate Medical Licensure Compact, Texas should continue enhancing license portability and enacting license reciprocity agreements.

NOTES:

According to the Legislative Budget Board, the bill would result in a positive impact of about \$480,000 through fiscal 2022-23.

SUBJECT: Modifying continuous eligibility periods for children enrolled in Medicaid

COMMITTEE: Human Services — committee substitute recommended

VOTE: 9 ayes — Frank, Hinojosa, Hull, Klick, Meza, Neave, Noble, Rose, Shaheen

0 nays

WITNESSES: For — Lindy McGee, American College of Physician Services Texas Chapter, Texas Academy of Family Physicians, Texas Children's Hospital, Texas Medical Association, and Texas Pediatric Society; Cesar Acosta, Central Texas Interfaith; Ana Maria Garza Cortez, Centromed and Texas Association of Community Health Centers; Christina Hoppe, Children's Hospital Association of Texas; Katie Mitten, Texans Care for Children; Linda Litzinger, Texas Parent to Parent; (*Registered, but did not testify*: Gregg Knaupe, Ascension Texas and Texas Association for Home Care and Hospice; Marisa Finley, Baylor Scott & White Health; Patricia Kolodzey, Blue Cross Blue Shield of Texas; Jason Sabo, Children at Risk; Michaela Bennett, Children's Health; Laura Guerra-Cardus, Children's Defense Fund -Texas; Amber Hausenfluck, CHRISTUS Health; Christine Wright, City of San Antonio; Dennis Borel, Coalition of Texans with Disabilities; Tim Schauer, Community Health Choice; Roberto Haddad, Doctors Hospital at Renaissance (DHR Health); Michael Dole, Driscoll Health Plan; Elisa Hernandez, El Paso Children's; Anne Dunkelberg, Every Texan (formerly CPPP); Susana Carranza, League of Women Voters of Texas; Lindsay Lanagan, Legacy Community Health; Myra Leo, Methodist Healthcare Ministries; Ana O'Quin, National Alliance on Mental Illness (NAMI) TX; Alison Mohr Boleware, National Association of Social Workers - Texas Chapter; Rebecca Galinsky and Hannah Mehta, Protect TX Fragile Kids; Maureen Milligan, Teaching Hospitals of Texas; Charles Miller, Texas 2036; Marshall Kenderdine, Texas Academy of Family Physicians; Gregg Knaupe, Texas Association For Home Care & Hospice; Laurie Vanhoose, Texas Association of Health Plans; Jennifer Biundo, Texas Campaign to Prevent Teen Pregnancy; Cameron Duncan, Texas Hospital Association; Joshua Houston, Texas Impact; Troy Alexander and Dan Finch, Texas Medical Association; Jill Sutton, Texas

Osteopathic Medical Association; Bonnie Bruce, Texas Society of Anesthesiologists; Kerrie Judice, TexProtects; Ashley Ford, The Arc of Texas; Jennifer Allmon, The Texas Catholic Conference of Bishops; Julie Wheeler, Travis County Commissioners Court; Ashley Harris, United Ways of Texas; Knox Kimberly, Upbring; Susan Burek; Idona Griffith; Georgia Keysor; Vanessa MacDougal; Suzanne Mitchell)

Against — None

On — (*Registered, but did not testify*: Janie Contreras, Health and Human Services Commission)

BACKGROUND: 42 U.S.C. sec. 1396a(e)(12) allows a state to provide that an individual who is under an age specified by the state, not to exceed 19 years old, and who is determined to be eligible for medical benefits under an approved state health care plan must remain eligible for those benefits until the earlier of the end of a period, not to exceed 12 months, following the eligibility determination or the time that the individual exceeds the specified age.

Human Resources Code sec. 32.0261 requires that the executive commissioner of the Health and Human Services Commission adopt rules to provide for a period of continuous eligibility for a child under 19 year old who is determined to be eligible for Medicaid in Texas. The rules must provide that a child remains eligible for medical assistance, without additional review by the commission and regardless of changes in the child's resources or income, until the earlier of the end of the six-month period following the date on which the child's eligibility for Medicaid was determined or the child's 19th birthday.

DIGEST: CSHB 290 would change the continuous eligibility period for children in the Texas Medicaid program from one to two consecutive periods of continuous eligibility between each certification and recertification of the child's eligibility for the program, provided certain income requirements were met. The Health and Human Services Commission (HHSC) could not recertify a child's eligibility for the Medicaid program more than once every 12 months in accordance with federal law. Regardless of any

provisions in the bill, a child's period of continuous eligibility for the Medicaid program would end on the child's 19th birthday.

Review of income. During the sixth month following the date a child's eligibility for the Medicaid program was certified, HHSC would be required to review the child's household income using electronic income data available to the commission and in a manner that complied with federal law. If the review indicated that the household income did not exceed the maximum income for Medicaid eligibility, the commission would have to provide a second continuous period of eligibility for the child until the child's annual recertification. If the review indicated that the household income exceeded the maximum allowed income for Medicaid eligibility, the commission could request additional documentation to verify the income in a manner that complied with federal law.

Upon determination that a child's household income exceeded the maximum allowed income for eligibility in the Medicaid program, the commission would be required to give the child's parent or guardian at least 30 days to provide documentation showing that the household income did not exceed the maximum allowed income. If the parent or guardian was able to provide the documentation within that time the commission would be required to provide the second period of continuous Medicaid eligibility to the child until the required annual recertification.

Notice of termination. If a child's parent or guardian failed to supply documentation that the household income did not exceed the maximum allowable income within the allotted 30 days, HHSC would be required to provide the parent or guardian with written notice of termination of the child's eligibility for the Medicaid program. This notice would have to include a statement that the child could be eligible for enrollment in the Children's Health Insurance Program (CHIP). The commission would have to consult with health care providers, children's health care advocates, family members of children enrolled in Medicaid, and other stakeholders in developing the termination notice to determine the most user-friendly method to provide the notice to a child's parent or guardian.

Other provisions. The HHSC executive commissioner could adopt rules as necessary to implement the bill's provisions. If a state agency

determined that a waiver or authorization from a federal agency was necessary for implementation of a provision before implementing it, the agency would be required to request the waiver or authorization and could delay implementing the provision until the waiver or authorization was granted.

The bill would take effect September 1, 2021.

**SUPPORTERS
SAY:**

CSHB 290 would ensure continuity of care for Texas children enrolled in Medicaid by providing two consecutive periods of continuous care for eligible children between annual certification and recertification. By addressing inefficiencies and inadequacies in the state's Medicaid system, the bill would streamline the Medicaid eligibility process for children, allowing for more children to continue receiving uninterrupted health care.

Currently Texas has the highest number and percentage of uninsured children in the country. After a decade of improvement, the numbers of uninsured Texan children began to worsen several years ago until the implementation of the current emergency federal requirement that Medicaid enrollment be maintained to prevent children from losing their health care coverage during the pandemic. CSHB 290 seeks to restore the Texas Medicaid policy that was in place from 2002 to 2014, which provided two consecutive six-month periods of continuous care, ensuring that fewer vulnerable children cycled on and off the program and were forced to go without health insurance.

The current Medicaid system for children is not working for families, providers, health plans, the Health and Human Services Commission (HHSC), or for local communities. Under this system, children enrolled in Medicaid receive six months of continuous care after they are determined to be eligible. This period is then followed by month-to-month income checks until the recertification process is initiated. These frequent income checks are burdensome for the children's families, who are often working long hours or multiple jobs and have to provide relevant documentation within a small period of time. Administrative agencies also must process the numerous income reviews, which can involve fixing gaps in coverage for qualified children and addressing duplicative applications. If a family

misses a deadline, or a mistake is made in the processing of an application, a child's health coverage can be terminated, which may lead to worse health outcomes for the child and to costly hospital interventions that burden counties and local taxpayers through payment for uncompensated care.

The value of Medicaid grows exponentially the longer a child has continuous coverage, as the continuity of care allows physicians to provide medically appropriate preventative and primary care for the child as well as referrals to specialists for more complex conditions. If there are gaps in coverage for children then appointments may be missed, physician practice burdens are increased, and the inability to access preventable treatment can lead to treatment for an emergency situation. CSHB 290 would reduce the number of children cycling on and off of insurance during the year, allowing doctors and plans to provide children enrolled in Medicaid with a stable source of high-quality care and leading to better health outcomes.

CSHB 290 would allow for continued state oversight while helping to eliminate inefficient and unnecessary bureaucratic hurdles. The bill would provide for a mid-year income check, giving a child's parent or guardian sufficient opportunity to address findings that their child may be ineligible for continued healthcare due to household income before the child's coverage was terminated. The bill also would maintain current Medicaid eligibility criteria, and it would require that notice to be provided to a parent or guardian of a child whose Medicaid coverage was terminated letting them know that the child could qualify for CHIP. This would reduce the likelihood that a child remained uninsured after Medicaid enrollment was terminated.

CRITICS
SAY:

No concerns identified.

SUBJECT: Authorizing local option homestead exemption for certain physicians

COMMITTEE: Ways and Means — favorable, without amendment

VOTE: 10 ayes — Meyer, Thierry, Button, Cole, Guerra, Martinez Fischer,
Murphy, Noble, Rodriguez, Shine

0 nays

1 absent — Sanford

WITNESSES: For — Carrie De Moor

Against — (*Registered, but did not testify*: Melissa Shannon, Bexar
County Commissioners Court)

DIGEST: HB 457 would provide that certain licensed physicians were entitled to an exemption from county property taxation of up to 50 percent of the appraised value of the physician's residence homestead, if such exemption was adopted by the county commissioners court. To be eligible, a physician would have to provide health care services to qualifying county residents and not seek payment for those services from any source, including the Medicaid program or other state or federal programs. A qualifying county resident would mean a resident who was indigent or a Medicaid recipient.

The commissioners court would have to specify in the order adopting the exemption the number of qualifying county residents to whom a physician had to provide health care services during a tax year to be eligible for the exemption. This number could be expressed as a percentage of the physician's total practice.

The bill would require the commissioners court to submit to the chief appraiser a copy of the order adopting the exemption and any subsequent order related to the exemption. The chief appraiser could require a physician seeking the exemption to present additional information to establish eligibility.

The commissioners court could repeal the exemption in the manner provided by law.

The bill would apply only to property taxes imposed for a tax year that began on or after the effective date.

The bill would take effect January 1, 2022, but only if the constitutional amendment proposed by this Legislature authorizing the local option property tax exemption for the residence homestead of physicians providing free health care for qualifying residents was approved by voters. If that amendment was not approved, the bill would have no effect.

**SUPPORTERS
SAY:**

HB 457, along with the constitutional amendment provided by HJR 25, would improve access to health care and reduce costs to the state by creating a tool for counties to incentivize physicians to participate in indigent health care. Existing care programs are growing more costly and the number of physicians in indigent programs is declining as they become frustrated over the administration of Medicaid. These barriers have caused health care programs for low-income or indigent patients to struggle to meet demand.

The legislation would address this issue by allowing a county to adopt a residence homestead exemption for physicians who provided health care to indigent residents or Medicaid recipients free of charge. This exemption could ease the burden on government programs, reduce uncompensated care costs, and engage the private sector on a volunteer basis.

The residence homestead exemption would be optional, allowing counties to limit property taxation by up to 50 percent for eligible physicians if they determined it useful. The enabling legislation also would provide that counties could determine eligibility for the exemption, allowing localities to tailor the exemption to their own revenue and health care needs.

**CRITICS
SAY:**

HB 457 and HJR 25 unnecessarily would create a residence homestead exemption on property taxes for physicians providing health care to indigent residents and Medicaid recipients. Instead of carving out specific

individuals from the tax base, limiting local revenues, the Legislature should expand Medicaid to provide effective health care to Texans.

OTHER
CRITICS
SAY:

HB 457 and HJR 25 would provide another property tax exemption for a specialized group, while the Legislature should be working to lower the tax burden on all Texans. The legislation would continue a problematic trend that increases the burden on some homeowners by lowering it for others.

NOTES:

HB 457 is the enabling legislation for HJR 25, which would amend the Texas Constitution to authorize a local option property tax exemption on the homestead residence of physicians providing free health care for qualifying residents. HJR 25 is on the Constitutional Amendments Calendar today.

SUBJECT: Extending Medicaid eligibility to 12 months after the end of a pregnancy

COMMITTEE: Human Services — favorable, without amendment

VOTE: 6 ayes — Frank, Hinojosa, Klick, Meza, Neave, Rose
3 nays — Hull, Noble, Shaheen

WITNESSES: For — Cynthia Humphrey, Association of Substance Abuse Programs; Lisa Hollier, American College of Obstetricians and Gynecologists, Children's Hospital Association of Texas, Texas Children's Health Plan, Texas Children's Hospital, Texas Hospital Association, and Texas Medical Association; Tom Hedrick, Dillon Joyce Ltd; Amelia Averyt, Doctors for Change; Lindsay Lanagan, Legacy Community Health; Bonnie Cook, Mental Health America of Greater Dallas; David Valdez, Molina Healthcare of Texas; Marjorie Quint-Bouzid, Parkland Health and Hospital System; Donna Kreuzer, Pregnancy and Postpartum Health Alliance of Texas; Adriana Kohler, Texans Care for Children; Laurie Vanhooose, Texas Association of Health Plans; Deneen Robinson, The Afiya Center; Paige Jackson; Michele Rountree; *(Registered, but did not testify)*: Blake Rocap, Avow; David White, Baylor Scott and White Health; Justin Till, Birth Equity Advocacy Project; Patricia Kolodzey, Blue Cross Blue Shield of Texas; Amber Hausenfluck, CHRISTUS Health; Christine Wright, City of San Antonio; Dennis Borel, Coalition of Texans with Disabilities; Tim Schauer, Community Health Choice; Lillian Painter, Dallas County Commissioners Court; Michael Dole, Driscoll Health Plan; Anne Dunkelberg, Every Texan (formerly CPPP); Ender Reed, Harris County Commissioners Court; Bill Kelly, Mayor's Office, City of Houston; Jason Sabo, Mental Health America; Greg Hansch and Ana O'Quin, National Alliance on Mental Illness (NAMI) TX; Alison Mohr Boleware, National Association of Social Workers - Texas Chapter; Andrew Cates, Nurse Family Partnership; Russell Schaffner, Tarrant County; Maureen Milligan, Teaching Hospitals of Texas; Tom Banning, Texas Academy of Family Physicians; Rene Lara, Texas AFL-CIO; Shelby Tracy, Texas Association of Community Health Centers; Kay Ghahremani, Texas Association of Community Health Plans; Jennifer Biundo, Texas Campaign to Prevent Teen Pregnancy; Sarah Crockett,

Texas CASA; David Reynolds, Texas Chapter American College of Physicians; Breall Baccus, Texas Council on Family Violence; Cesar Lopez, Texas Hospital Association; Joshua Houston, Texas Impact; Dan Finch, Texas Medical Association; Kevin Stewart, Texas Nurses Association; Eric Woomer, Texas Pediatric Society; Jessica Magee, Texas Psychological Association; Kerrie Judice, TexProtects; Jennifer Allmon, The Texas Catholic Conference of Bishops; Julie Wheeler, Travis County Commissioners Court; Molly Weiner, United Ways of Texas; Elisa Hernandez, University Medical Center of El Paso; Vanessa MacDougal; Thomas Parkinson)

Against — None

On — (*Registered, but did not testify*: Hilary Davis, Michael Ghasemi, and Stephanie Stephens, Texas Health and Human Services Commission)

BACKGROUND: 42 C.F.R. sec. 435.170 requires that pregnant women eligible and enrolled in Medicaid on the date their pregnancy ends must be provided with coverage through the last day of the month in which the 60-day postpartum period ends.

DIGEST: HB 133 would require the Health and Human Services Commission (HHSC) to continue to provide health benefits to a woman eligible for Medicaid for pregnant women for at least 12 months following the date of a delivery or involuntary miscarriage.

If a state agency determined that a waiver or authorization from a federal agency was necessary to implement the bill, the agency would have to request the waiver and would be permitted to delay implementation of the bill until the waiver or authorization was granted.

The bill would take effect September 1, 2021.

SUPPORTERS SAY: HB 133 would help to ensure that Texas women had healthy pregnancies and better long-term health outcomes by extending Medicaid benefits for pregnant women from 60 days to 12 months post-partum.

Concerns have been raised over data contained in the 2020 biennial report submitted by the Maternal Mortality and Morbidity Review Committee and the Department of State Health Services (DSHS) indicating that nearly 40 percent of maternal death cases in Texas were related to pregnancy. According to the study, black women and women enrolled in the Medicaid program were more likely to experience pregnancy-related death, and the report suggested that a majority of pregnancy-related deaths are preventable. The report also indicated that 31 percent of the pregnancy-related deaths occurred 43 days to 1 year after the end of the pregnancy.

HB 133 would address specific concerns about intermittent insurance coverage for eligible mothers after pregnancy by providing comprehensive continuous care during the critical postpartum period when health issues often arise. Uninsured women are less likely to receive preventative care and services for chronic disease, and many of these women seek health care for the first time after they become pregnant without knowledge of any underlying health conditions that they may have. Providing 12 months of comprehensive, continuous health care for these women postpartum would give doctors more uninterrupted time to address complications that can arise post-pregnancy and to address long-term health outcomes for these women.

Current Texas family planning and women's health programs that provide health coverage for eligible women postpartum do not provide comprehensive health coverage for a 12-month period. In addition, recent changes to the eligibility, enrollment policies, and practices of the Healthy Texas Women (HTW) program will likely lead to a significant gap in coverage and leave a large percentage of formerly eligible women out of the program. Other programs for extended maternal care after pregnancy often must secure funding without state or federal help, which limits these programs to serving only the most vulnerable women. Even if women are eligible for a Texas program, they are often faced with a lack of certain specialized services or face prohibitive financial hurdles for services for which they otherwise qualified. HB 133 would address limitations of the current Texas programs by providing all eligible women with 12 months of comprehensive health care services postpartum.

HB 133 would not expand Medicaid eligibility to pregnant women who were not eligible for enrollment before the bill. Rather, it would extend comprehensive postpartum care for these eligible women to 12 months, which is the recommended extension for addressing disruptions in coverage and access to needed care. Although this extension of services would likely result in a negative fiscal impact for the state, it is expected to result in savings to the Medicaid program from averted births and savings to the HTW program because individuals receiving benefits from that program would instead receive benefits through the extended Medicaid coverage. Further, it has been recommended that the federal government should provide a 100 percent fiscal match for the extension of services.

CRITICS
SAY:

HB 133 may not adequately address the state's maternal mortality and morbidity program, and pregnant women in Texas could be better served if time and resources were spent on other solutions. Over the last several years, Texas has focused a considerable amount of attention and resources on the number of Texas women who die due to health issues arising during pregnancy or in the postpartum period, and programs like Healthy Texas Women have already been implemented to address these issues. Providing more services over a longer period of time may not adequately address the maternal mortality and morbidity issue, the causes of which are not definitively known, and could cost the state time and money that may be better spent addressing other potential factors contributing to this issue.

NOTES:

According to the Legislative Budget Board, the bill would have a negative impact of about \$84 million to general revenue related funds through the biennium ending August 31, 2023.

SUBJECT: Requiring disclosures of certain health care costs to enrollees and public

COMMITTEE: Insurance — favorable, without amendment

VOTE: 9 ayes — Oliverson, Vo, J. González, Hull, Israel, Middleton, Paul,
Romero, Sanford

0 nays

WITNESSES: For — Daniel Chepkauskas, Patient Choice Coalition; Charles Miller,
Texas 2036; Carl Isett, Texas Association of Benefit Administrators;
Doug Aldeen; (*Registered, but did not testify*: Kyle Frazier, Kyle Frazier
Consulting)

Against — Cameron Duncan, Texas Hospital Association

On — Jamie Dudensing, Texas Association of Health Plans; (*Registered,
but did not testify*: Luke Bellsnyder, Texas Department of Insurance)

DIGEST: HB 2090 would require a health benefit plan issuer or administrator to
disclose to enrollees and the public certain health care cost information.
The bill would specify formats for disclosing information electronically
and in hard copy and would define several terms, including "bundled
payment arrangement," "cost-sharing liability," "negotiated rate," and
"accumulated amounts."

Definitions. "Bundled payment" would be defined as a payment model
under which a health care provider was paid a single payment for all
covered services and supplies provided to an enrollee for a specific
treatment or procedure.

"Cost-sharing liability" would mean the amount an enrollee was
responsible for paying for a covered health care service or supply under a
health benefit plan's terms. The term would generally include deductibles,
coinsurance, and copayments but would not include premiums, balance
billing amounts by out-of-network providers, or the cost of health care
services or supplies not covered under a health plan.

"Negotiated rate" would mean the amount a health plan issuer or administrator had contractually agreed to pay a network provider, including a network pharmacy or other prescription drug dispenser, for covered health care services and supplies, including through a third-party administrator or pharmacy benefit manager.

"Accumulated amounts" would mean the amount of financial responsibility an enrollee incurred at the time a request for cost-sharing information was made, with respect to a deductible or out-of-pocket limit and the amount that accrued toward a cumulative treatment limit on the health care service or supply. The bill would include other specified provisions in the definition.

Applicability. The bill would apply only to certain health plans issued by a specified organization, including:

- a plan issued by a health maintenance organization;
- a small employer health plan subject to the Health Insurance Portability and Availability Act;
- a consumer choice of benefits plan;
- a basic coverage plan under the Texas Employees Group Benefits Act;
- a basic plan under the Texas Public School Retired Employees Group Benefits Act;
- a primary care coverage plan under the Texas School Employees Uniform Group Health Coverage Act; and
- a basic coverage plan under the Uniform Insurance Benefits Act for employees of the University of Texas and Texas A&M systems.

The bill would not apply to a health reimbursement arrangement or other account-based health benefit plan.

Enrollee disclosures. The bill would require a health plan to disclose certain cost-sharing liability information to the enrollee upon request. If allowed by the health plan, an enrollee could request cost-sharing information for a specific preventive or non-preventive health care service

or supply by including terms like "preventive," "non-preventive," or "diagnostic" when making the request.

The cost-sharing information provided to the enrollee would have to be accurate and include:

- an estimate of the enrollee's cost-sharing liability for the requested service or supply;
- the cost-sharing liability for non-preventive purposes under certain circumstances;
- accumulated amounts;
- the network provider rate containing the negotiated rate and underlying fee schedule rate, as applicable; and
- the out-of-network allowed amount; and
- notice that applicable coverage of a service or supply was subject to a prerequisite, among other specified provisions.

The information also would have to explain in plain language balance billing, actual charges, cost-sharing liability, copayment assistance, and other information deemed appropriate.

Bundled payment arrangement. A health plan would not have to provide an estimate of cost-sharing liability for a bundled payment arrangement in which the cost sharing was imposed separately for each service or supply. If a health plan provided relevant estimates for multiple services or supplies, the health plan would have to disclose the information for relevant services or supplies individually.

Formats. The bill would require a health plan to disclose the cost-sharing liability information through an internet-based self-service tool, a physical copy, or another specified way.

Information provided on the self-service tool would have to be available in plain language, without a subscription or other fee, on a website providing real-time responses based on accurate cost-sharing information. The self-service tool would have to allow a user to:

- search for cost-sharing information by inputting a billing code, the network provider's name, or other relevant factors;
- search for an out-of-network allowed amount, percentage of billed charges, or other rate providing a reasonably accurate estimate of the amount a health plan would pay for a covered service or supply by inputting a billing code or other relevant factors; and
- refine and reorder search results based on geographic proximity of network providers and the amount of the enrollee's estimated cost-sharing liability.

A physical copy of a disclosure would have to be provided in plain language, without a fee, at the enrollee's request.

These provisions would only apply to a health benefit plan issued or renewed on or after January 1, 2024.

Public disclosures. Under the bill, a health plan would have to publish on a website three machine-readable files containing a network rate for all covered health care services and supplies, with some exceptions, and an out-of-network allowed amount and prescription drug for each coverage option.

Network rates. The file for network rates would have to include the following for all covered health care services and supplies, except for prescription drugs subject to a fee-for-service reimbursement arrangement:

- for each coverage option, the option's name and unique identifiers;
- a plain-language description of each billing code; and
- all applicable rates, including negotiated rates, underlying fee schedules, or derived amounts as specified in the bill.

The bill would specify other amounts required to be disclosed by health plans that did not use negotiated rates for provider reimbursement and/or those that used the underlying fee schedule rates for calculating cost sharing.

The applicable rates, including for individual health care services and supplies and those in a bundled payment arrangement, that a health plan would have to provide would include:

- with some exceptions, the dollar amounts for each covered service or supply provided by a network provider; and
- the base negotiated rate applicable to the service or supply before an adjustment for enrollee characteristics if the rate was a negotiated rate subject to change based on those characteristics; and
- other specified provisions.

Out-of-network allowed amounts. The file for out-of-network allowed amounts would include the following information:

- for each coverage option, the option's name and unique identifiers;
- a plain-language description of each billing code; and
- unique out-of-network billed charges and allowed amounts as specified in the bill.

Certain out-of-network allowed amounts would have to be reflected as a dollar amount for each service or supply and other identifiers.

Prescription drugs. The file for prescription drugs would include the following information:

- for each coverage option, the option's name and unique identifiers;
- the national drug code and the proprietary and nonproprietary name assigned by the U.S. Food and Drug Administration;
- the negotiated rates; and
- historical net prices with certain exceptions.

The bill would not require the disclosure of information that would violate any applicable health information privacy law.

These provisions would only apply to a health benefit plan issued or renewed on or after January 1, 2022.

Other provisions. The bill would specify provisions in which a health plan issuer or administrator that acted in good faith and with reasonable diligence met compliance standards.

The commissioner of the Texas Department of Insurance could adopt rules to implement the bill's provisions.

The bill would take effect September 1, 2021.

**SUPPORTERS
SAY:**

HB 2090 would improve price transparency for consumers by codifying federal rule that requires health plans to disclose certain health care cost information.

Currently, health care prices often are opaque, leaving consumers without adequate information to make decisions regarding health care services. The bill would increase consumers' access to health care cost information, empowering them to make more informed choices about their health care prior to receiving services. The bill also would help address a lack of provider competition and unsustainable health care price growth in Texas.

Any concerns about the bill conflicting with federal rules if those rules changed could be addressed in a floor amendment.

**CRITICS
SAY:**

By permanently codifying into state law a federal price transparency rule, the HB 2090 could make it more difficult for health plans to adhere to current law if the federal rule changed. Rather than potentially creating two separate price transparency structures under federal and state law, the bill should include a reference to the federal rule in case that rule changed.

Additionally, by requiring the public disclosure of privately negotiated rates, the bill could create scenarios in which reimbursement rates decreased for health care providers decreased.

NOTES:

The author intends to offer a floor amendment that would specify that Insurance Code ch. 1662, subch. C would apply only to a health benefit

plan for which federal reporting requirements under 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158 did not apply.